

Before the  
**FEDERAL COMMUNICATIONS COMMISSION**  
Washington, D. C. 20554

In the Matter of:

)

Notice of Proposed Rulemaking (NPRM) )WC Docket No. 02-60  
Regarding the Universal Service Support Mechanism )  
for Rural Healthcare.

**Comments of the American Telemedicine Association,  
Washington, D.C.**

**I. INTRODUCTION**

The American Telemedicine Association (ATA), Washington, D.C., respectfully submits the following comments in response to the Notice of Proposed Rulemaking (NPRM) in the above captioned proceeding.

ATA submits these comments in response to the following requests by the Commission:

- 1) **Internet Access** – The Commission seeks comment on “whether a 25 percent flat discount off the cost of monthly Internet access for eligible rural health care providers is sufficient. The Commission also seeks comments on the effect that an increase in Internet access support would have on the demand for support from rural health care providers (FCC 04-289; V(a)(1)(para 47, 48).
- 2) **Support for Other Telecommunication Services for Mobile Rural Health Care Providers** – The Commission seeks comments on whether to modify (the) rules

specifically to allow mobile rural health care providers to use services other than satellite; on what other telecommunications services might be available to support mobile rural telemedicine projects; how such services may be a more cost-effective method of providing service than a satellite connect; and whether services other than satellite services would require different rules, different eligibility criteria or any other changes from the rules (we) establish (today) (FCC 04-289; V(b)(para 50).

- 3) **Support for Infrastructure Development** – The Commission seeks anecdotal evidence regarding the need for support for infrastructure development, and to refresh the record. Specifically, the Commission asks whether the Commission should authorize support for upgrades to the public switched or back-bone networks? (FCC 04-289; V(c)(para 51-53).

## II. SUMMARY OF ATA'S POSITION

The American Telemedicine Association gratefully acknowledges the work of the Commission in maintaining and supporting the expansion of the Universal Service Mechanism (USM) for Health Care's ability to provide subsidies to health care providers and organizations through USAC's Rural Health Care Division. We applaud the Commission's continued emphasis on reviewing options to allow as many rural health care providers as possible the opportunity to have broadband capabilities for Internet access and telecommunications that support the deployment of electronic medical records and Telehealth/Telemedicine applications.

The American Telemedicine Association is generally in support of the recent FCC 04-289 Second Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking. We support a subsidy for Internet service, but respectfully request that the amount of that subsidy be raised from 25% to 75% with the addition of a not to exceed cap placed on the amount of the subsidy. We support the use of satellite services within a limited scope with certification for its use administered by RHCD. We do not support the authorization of subsidies for the support of infrastructure upgrades to the public switched or backbone networks, but we do support infrastructure subsidies for infrastructure upgrades within the health care organizations themselves.

### **III. BACKGROUND**

Telemedicine networks have their origin in costly point-to-point proprietary lines supported mainly by large investigational grants, going back as far as the early 1960s. Current Telehealth/Telemedicine networks use a combination of telecommunications services including statewide ATM networks, T1, ISDN, frame relay, wireless and in some instances, satellite networks. Most states in the lower 48 use a combination of land lines. Satellite and wireless services are typically reserved for areas that have no telecommunications services (such as along the Texas/Mexico border, frontier areas in Montana and Wyoming, and parts of Arizona and New Mexico, where the use of military systems is prevalent) and for areas with geographic and natural barriers such as Alaska and Hawaii. Although the cost of many telecommunications lines has decreased over the last decade but often remain as much as \$1,200 per month range for a full T1, \$300-\$2,700

for a 3-BRI ISDN, and can be even higher for other combinations of lines. Currently, most transmission speeds need to approximate 256-384 kbps for acceptable quality for real-time Telehealth interactions. Cable modem access, DSL, and other lower bandwidth strategies have been employed when the cost of higher quality lines is prohibitive, but there are significant technical issues when selecting these services (e.g., bandwidth starvation, loss of Quality of Service, etc.). Video protocols such as H.320, H.323, and H.324 have been implemented as a part of health care networks. Satellite and wireless communication standards are often used when no other wireline service is available. The lack of any coverage, other than satellite or wireless, is rare and typically limited to geographic areas that have significant weather barriers or have no landlines.

In 2003 (the last year for unduplicated statistics), the RHCD supported approximately 4 post-secondary institutions, 131 community health centers, 246 local health departments, 126 community mental health centers, 532 non-profit hospitals, and 584 rural health clinics (total of 1623). The total amount that is authorized to support these types of facilities is \$400 million per year. The total amount of commitments in 2003 for dollars was \$25.8 million (about seven percent of the total).

The 2004 applications to RHCD indicate that approximately 911 health care providers filed for broadband support and 315 sought Internet-only funding. Internet became a covered RHCD service in 2004. Satellite transmission also became a covered service outside of Alaska in 2004. Currently, there are no fixed based satellite funding commitments outside of Alaska and there are no 2004 applications for mobile satellite services. According to staff at the RHCD, no eligible health care providers have been able to

support, through petition or affidavit, that satellite services were the only option available to meet their needs (RHCD communication 4-4-2005).

#### IV. ARGUMENT

**Internet** – The use of the USM for Internet access to rural providers should be a high priority for the FCC for several reasons.

- It is clear that rural care providers, including physicians and hospitals are not on the incline – in fact, they have shown a trend towards a significant decline. The United States has long held a policy of supporting rural providers in an effort to stem such drain from rural communities. One critical factor in keeping rural providers is allowing them access to continuing medical education, reference files and direct access to specialists and tertiary care facilities located outside of their region. Indeed, retention of rural health care providers is one of the motivating factors in the original drafting of the rural health language in the Telecommunications Act.
- The adoption of electronic medical records and other telecommunications will bridge the gap between rural providers and health organizations and support the federal government's National Health Information Technology (NHIT) plan to connect physicians, provide up-to-date patient information, and foster collaboration among providers. Facilitating such networking in rural areas will require an increased level of support from USF for Internet services. Many such networks are already

springing up as the nation responds to the NHIT initiative. For example, in Tennessee, the Tennessee Primary Care Association is forming a Community Health Network. The network is already functional providing Internet and practice management services. EMR is to be added early in 2006. A T-1 line goes to each site. A multi-county CHC business and other groups are promoting the network. The typical CHC clinic on the network has 2 to 4 practitioners (MDs and NPs). However, not all practitioners are able to receive affordable Internet services. Internet subsidies can significantly help this fledgling network's ability to attract and sustain new members.

To better understand the potential impact that increasing the subsidies for Internet service will have on the USM, one must first understand the potential number of applicants. Below are a couple statistics that indicate the approximate number of hospitals and clinics operating within the United States.

- The Office of Rural Health Policy reported that there were 56,635 physician offices in 1995 (last ORHP compiled statistics). ( <http://www.shepscenter.unc.edu> ).
- The American Hospital Association's Society for Health Care Strategy and Market Development estimates that the number of rural hospitals in 1997 was 2,200. (source: AHA, ([www.hospitalconnect.com/shsmd/resources/profileofhealth](http://www.hospitalconnect.com/shsmd/resources/profileofhealth))).

Assuming that the USM would pay \$100 per month for Internet access for *all* existing rural physician offices and rural hospitals (58,835 total facilities), the total USM subsidy would be \$5,883,500 monthly, \$70,602,000 annually, or only 17.65% of the total \$400 million authorized to be spent under the USM for health care. Of course, not every hospital or clinic will participate in the USM program and there is no expectation that the number of rural health providers, including physicians and hospitals, will significantly increase in the next decade. Thus, even if all current providers participate, there is no likelihood that providing an increased subsidy will have a significant enough effect on the bottom line of the budget of USM to put the fund in danger.

**Satellite Services** – The Commission assumes that satellite mobile services visiting eight (8) or more sites per year is more cost-effective than multiple wire line sites that may sit idle for the majority of the year. Although this assumption may seem reasonable, the economics may not always follow.

The goal of any provider using satellite service is to provide technology that is both scaleable and provides flexibility for transport and connectivity within and outside of existing networks. In addition, most of the existing networks are moving toward an open architecture. In its simplest form, the goal of using satellite services is to provide service where in fact, there is none or where alternatives are far too costly. However, for most parts of the country, satellite service is not the only option or more economical than wire line service. Exceptions to this occur in Alaska, Hawaii, and along the U.S. and Mexico borders.

Mobile services typically travel to other health care buildings, schools, etc., that have some capabilities for broadband. Facilities that have Internet service can usually provide at least medical store-and-forward bandwidth capable of transmitting large files and usually have access to some form of broadband service. Mobile services that travel to any facility with broadband capabilities, particularly existing video service, can link to that service.

**Infrastructure Development** – Currently, telecommunications carriers are loathe to place broadband in areas where there is not a significant revenue potential. However, this does not stop the deployment of many miles of dark fiber in the U.S. Most telecommunications carriers claim that to build the last mile, a significant revenue source must be in place. The barrier is not always geographic in nature. In the state of Wisconsin, ILECs are allowed to purchase service from the CLECs at a discounted rate, only to turn around and sell to the CLECs own customers, at a rate less than the CLEC can afford to charge. This odd sense of fairness relates to regulatory language intended to bring more carriers of broadband into the state.

In most health care institutions, the ability to connect to any service available is a costly venture. Capital investments of this large of a sum typically engulfs a rural facilities margin and may mean the difference between having no service and being able to provide new automatic blood pressure machines for the surgical suite or a new cardiac monitor for the emergency department.

Subsidizing upgrades to the public switched or backbone networks provides telecommunications carriers with public monies on which to build networks that would then

be used for commercial, profit-generating initiatives. There is no way to stop the commercial use of infrastructure once it is built and continues to be owned by the telecommunications carriers. A more prudent approach would be to pay for infrastructure development at the rural health care organization.

The limiting parameters of the rural health program and the advantage of new technology will make the cost of such infrastructure upgrades very small compared to costs charged to the USM's School and Library Program. Rural health applicants must go through a process with RHCD that certifies their rurality, certifies their non-profit status, and certifies that the infrastructure (currently only the line charges) is used the majority of the time for the provision of health care services. RHCD would be ensured that the funding would be used for rural health care deployment, stabilization of rural health practices, and the provision of specialty care services to remote and disparate populations. Further measures might be considered to limit the cost of such services such as placing a priority on the use of wireless networks, rather than wiring entire facilities.

## **V. RECOMMENDATIONS**

The American Telemedicine Association respectfully submits the following recommendations for the three areas outlined above:

- 1) Internet Access – The American Telemedicine Association recommends that the Internet access rate be increased from 25% to 75%, but in no case will the subsidy exceed the highest monthly rate posted for T1 service in each respective state. The benefit in providing higher subsidies will allow a greater percentage of

organizations to use the cost savings to further pay for broadband capabilities or other technological support systems needed to provide effective health care solutions in rural areas, without having a negative impact on the stability of the RHCD fund.

- 2) Satellite Subsidies – The American Telemedicine Association makes the following recommendations based on the request for comments on whether to modify the rules specifically to allow mobile rural health care providers to use services other than satellite:
  - a. That mobile rural health care providers (MRHCs) be required to apply to the USF/RHCD under separate process to determine eligibility for subsidies for satellite services;
  - b. That MRHCs be required to provide affidavits stating that no other options are available for telecommunications transmission in the designated mobile service area with their application;
- 3) Infrastructure Development – The American Telemedicine Association recommends that the FCC develop a strategy for paying for infrastructure development within eligible health care organizations as this is typically a greater barrier than paying for public switched or back-bone networks.

The American Telemedicine Association submits these comments in response to the Notice of Proposed Rulemaking (NPRM) of the FCC 04-289 Second Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking. (*Second Report and Order*).

Respectfully submitted,

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